

## PHYSICIAN AUTHORIZATION

Name:		Telephone:	
Address:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
City:	Zip:	DOB:	SSN:

### Current Medical Exam

Diagnosis	ICD Code	Normal	Normal
		General	Lungs
		H.E.E.N.T.	Heart
		Mouth	Abdomen
		Thorax	Genitourinary
		Breast	Musco-skeletal
		Lymphatic	Rectal
		Special Instructions:	

### Diet and Nutrition

<input type="checkbox"/> Regular	<input type="checkbox"/> Low NA	<input type="checkbox"/> Low Cholesterol
<input type="checkbox"/> Diabetic	<input type="checkbox"/> Puree	<input type="checkbox"/> Renal
<input type="checkbox"/> Other: _____		

### Allergies

Does patient have any known allergies?  No  Yes \_\_\_\_\_

### Okay for PRN use while at center

<b>Pain</b>	
<input type="checkbox"/> Aspirin (5g), 2 tablets, q 4 hours with food	<input type="checkbox"/> Advil (200mg), 1 tablet, q 4 hours with food
<input type="checkbox"/> Tylenol (325mg), 2 tablets, q 4 hours	<input type="checkbox"/> Other: _____
<b>Stomach Upset/ Intestinal Distress</b>	
<input type="checkbox"/> Antacid, 30cc, q 4 hours	<input type="checkbox"/> Laxative (M.O.M.), 30cc, prn QD constipation
<input type="checkbox"/> Kaopectate, 2 tbs, prn diarrhea	<input type="checkbox"/> Pepto Bismol, 30ml, q 30-60 minutes, prn diarrhea

### TB clearance (within the last 12 months) – Required prior to admission into the program

Date of test: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	Method: <input type="checkbox"/> PPD Test <input type="checkbox"/> Chest XRAY
Do you authorize licensed nursing staff to administer a PPD skin test at the center? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Any indication of a communicable disease? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please explain) _____	

### Special Orders

All participants attending the center are monitored by an RN, who will notify you of any significant problems.	
Blood glucose testing order? <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Other: _____	
<b>Do you wish to be notified if :</b>	
Blood sugar: 2 HRS. AC breakfast <70mg/dl >140mg/dl <input type="checkbox"/> Yes <input type="checkbox"/> No If BS <70 mg/dl offer 120cc. juice/milk <input type="checkbox"/> Yes Other Parameters: _____	Blood pressure: <90/60- >160/90 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other Parameters: _____
Pulse <60>110 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other Parameters: _____	
Does patient have any medical contraindications for transportation time in excess of 60 minutes? <input type="checkbox"/> No <input type="checkbox"/> Yes ( If yes, please explain) _____	
<b>I AUTHORIZE PARTICIPATION AT AMONG FRIENDS ADHC</b>	

### Physician Authorization

Physician Printed name:	Date:
Physician's Signature	Telephone:

## PHYSICIAN AUTHORIZATION

Name:		Telephone:
Address:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
City:	Zip:	DOB:

### Medications

Medication Name	Dosage	Directions	Prescribing MD	Diagnosis
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

<b>Is this patient capable of self-administration of medications while at the center?</b>	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
---	--	---------------------------------------

### Physician Recommendations


### Physician Authorization

Printed name:	Date:
Physician's signature:	Telephone: